		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033803

Facility Name: Anchorage of Beecher

Address: 1201 Dixie Highway (Number) Beecher (City) 60401 (Zip Code)

County: Will

Telephone Number: 708-946-2600 **Fax #** 708-946-9411

HFS ID Number: 36-2166970-002

Date of Initial License for Current Owners: 09/12/1988

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
	[X] Charitable Corp.		[ ] Individual		[ ] State
	[ ] Trust		[ ] Partnership		[ ] County
IRS Exemption Code 501©3			[ ] Corporation		[ ] Other
			[ ] "Sub-S" Corp.		
			[ ] Limited Liability Co.		
			[ ] Trust		
			[ ] Other		

In the event there are further questions about this report, please contact:
Name: Donald Primdahl **Telephone Number:** 630-521-8034

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/04 to 06/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Thomas L. Noesen, Jr.

(Title) Treasurer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,773	9,314	3,730	29,817	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,773	9,314	3,730	29,817	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.09%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, Staff Food Services

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/12/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 3,730

Medicare Intermediary Adminastar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/05 Fiscal Year: 06/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,382	15,782	7,554	218,718		218,718		218,718			1
2	Food Purchase		187,626		187,626	(5,894)	181,732	(8,421)	173,311			2
3	Housekeeping	110,047	28,424		138,471		138,471		138,471			3
4	Laundry			75,809	75,809		75,809		75,809			4
5	Heat and Other Utilities			67,106	67,106		67,106		67,106			5
6	Maintenance	68,970	11,630	24,705	105,305		105,305		105,305			6
7	Other (specify):*											7
8	**TOTAL General Services**	374,399	243,462	175,174	793,035	(5,894)	787,141	(8,421)	778,720			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	1,618,911	278,061	71,848	1,968,820	(61,520)	1,907,300		1,907,300			10
10a	Therapy	88,413	2,530	216,310	307,253		307,253		307,253			10a
11	Activities	70,595	2,672	12,589	85,856		85,856		85,856			11
12	Social Services	62,227		700	62,927		62,927		62,927			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,840,146	283,263	315,247	2,438,656	(61,520)	2,377,136		2,377,136			16
	C. General Administration											
17	Administrative	80,063			80,063	91,137	171,200		171,200			17
18	Directors Fees											18
19	Professional Services			578,981	578,981	(115,260)	463,721	(386,115)	77,606			19
20	Dues, Fees, Subscriptions & Promotions			11,887	11,887	198	12,085	(4,779)	7,306			20
21	Clerical & General Office Expenses	108,263	15,980	103,934	228,177	5,752	233,929	(49,139)	184,790			21
22	Employee Benefits & Payroll Taxes			606,306	606,306	18,136	624,442		624,442			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,180	4,180	411	4,591		4,591			24
25	Other Admin. Staff Transportation			2,994	2,994	103	3,097		3,097			25
26	Insurance-Prop.Liab.Malpractice			76,955	76,955		76,955		76,955			26
27	Other (specify):*											27
28	**TOTAL General Administration**	188,326	15,980	1,385,237	1,589,543	477	1,590,020	(440,033)	1,149,987			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,402,871	542,705	1,875,658	4,821,234	(66,937)	4,754,297	(448,454)	4,305,843			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Anchorage of Beecher #0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,872	25,872		25,872	59,812	85,684			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			173,208	173,208		173,208	(8,714)	164,494			32
33	Real Estate Taxes			2,600	2,600		2,600	(2,600)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,407	13,407	(13,407)						35
36	Other (specify):*											36
37	**TOTAL Ownership**			215,087	215,087	(13,407)	201,680	48,498	250,178			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			14,429	14,429	74,450	88,879		88,879			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops					5,894	5,894		5,894			41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			66,989	66,989	80,344	147,333		147,333			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,402,871	542,705	2,157,734	5,103,310		5,103,310	(399,956)	4,703,354			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,421)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	59,812	30		9
10	Interest and Other Investment Income	(641)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(8,073)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,139)	21		24
25	Fund Raising, Advertising and Promotional	(4,779)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See 5 A	(385,715)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (396,956)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (396,956)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops	X		5,894	2	40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs	X		74,450	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 80,344		47

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Anchorage of Beecher

ID# **0033803**

Report Period Beginning: **07/01/04**

Ending: **06/30/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adjoining Property Tax	$ (2,600)	33	1
2	Cost of Proposed Sale - Cain Brothers	(50,960)	19	2
3	Cost of Proposed Sale - Interlinks	(8,694)	19	3
4	Allocated G & A Not Allowed	(323,461)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(385,715)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Anchorage of Beecher # 0033803 **Report Period Beginning:** 07/01/04 **Ending:** 06/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,421)	0	0	0	0	0	0	0	0	0	0	(8,421)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,421)	0	0	0	0	0	0	0	0	0	0	(8,421)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(383,115)	(3,000)	0	0	0	0	0	0	0	0	0	(386,115)	19
20	Fees, Subscriptions & Promotions	(4,779)	0	0	0	0	0	0	0	0	0	0	(4,779)	20
21	Clerical & General Office Expenses	(49,139)	0	0	0	0	0	0	0	0	0	0	(49,139)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(437,033)	(3,000)	0	0	0	0	0	0	0	0	0	(440,033)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(445,454)	(3,000)	0	0	0	0	0	0	0	0	0	(448,454)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Anchorage of Beecher** **# 0033803** **Report Period Beginning:** **07/01/04** **Ending:** **06/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	59,812	0	0	0	0	0	0	0	0	0	0	59,812	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,714)	0	0	0	0	0	0	0	0	0	0	(8,714)	32
33	Real Estate Taxes	(2,600)	0	0	0	0	0	0	0	0	0	0	(2,600)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	48,498	0	0	0	0	0	0	0	0	0	0	48,498	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(396,956)	(3,000)	0	0	0	0	0	0	0	0	0	(399,956)	45

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bensenville Home Society	100	Anchorage of Bensenville	Bensenville	Lifelink Area		Independent
Lifelink Corporation (BHS Parent)	100	Pine Acres care Center	DeKalb	Housing	Various	Living
				Bridgeway of		Independent
				Bensenville	Bensenville	Living
				Lifelink Charities	Bensenville	Fund Raising
				Lifelink Services	Bensenville	Proj. Devel.
				See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Management Fees	$ 4,321	Lifelink Corporation (Corporate Health Care)	100.00%	$ 1,321	$ (3,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 4,321			$ 1,321	$ * (3,000)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NO COMPENSATION IS PAID TO ANY OWNERS, RELATIVES OR BOARD MEMBERS								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LIFELINK CORPORATION
Street Address: 331 S. YORK ROAD
City / State / Zip Code: BENSENVILLE, IL. 60106
Phone Number: (630) 521-8034
Fax Number: (630) 521-8067

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATION	DIRECT PROG. COST	66,207,782	12	$ 1,182,362	$ 1,182,362	5,103,310	$ 91,137	1
2	19	PROFESSIONAL SERVICES	DIRECT PROG. COST	66,207,782	12	243,935		5,103,310	18,803	2
3	20	FEES, SUBSCRIPTIONS, PROM	DIRECT PROG. COST	66,207,782	12	2,242		5,103,310	173	3
4	21	GEN. OFFICE EXPENSE	DIRECT PROG. COST	66,207,782	12	61,993		5,103,310	4,778	4
5	22	EMP. TAXES & BENEFITS	DIRECT PROG. COST	66,207,782	12	235,289		5,103,310	18,136	5
6	24	TRAVEL & SEMINARS	DIRECT PROG. COST	66,207,782	12	5,326		5,103,310	411	6
7	25	OTHER STAFF TRANS.	DIRECT PROG. COST	66,207,782	12	1,332		5,103,310	103	7
8	35	RENTAL EQUIPMENT	DIRECT PROG. COST	66,207,782	12	1,514		5,103,310	117	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,733,993	$ 1,182,362		$ 133,658	25

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1			X	REFINANCE MORTGAGE	***	***	$ ***	$ ***	***	***	$ 165,136	1
2				AND CAPITAL PROJECTS								2
3												3
4				*** SEE ATTACHED								4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 165,136	9
	B. Non-Facility Related*											
10	IDPA REPAYMENT PLAN										8,072	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 8,072	14
15	TOTALS (line 9+line14)						$	$			$ 173,208	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 0 **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 0	2
3. Under or (over) accrual (line 2 minus line 1).	$ 0	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 0	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$ 0	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$ 0	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	0	8
2001	0	9
2002	0	10
2003	0	11
2004	0	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Anchorage of Beecher COUNTY Will

FACILITY IDPH LICENSE NUMBER 0033803

CONTACT PERSON REGARDING THIS REPORT Donald Primdahl

TELEPHONE 630-521-8034 FAX #: 630-521-8067

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-22-16-200-021-0000	Vacant	$ 2,674.80	$ 0
2.	22-22-16-200-028-0000	Nursing Home	$ 0	$ 0
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 2,674.80	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,095 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	LONG TERM CARE	123,116	1988	$ 246,000	1
2					2
3	TOTALS	123,116		$ 246,000	3

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		1988	1985	$ 2,456,000	$ 37,785	40	$ 61,400	$ 23,615	$ 1,000,820	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1985 ADMIN. BLDG. RENOVATION			1985	133,766	3,344	40	3,344		95,913	9
10	1986 ADMIN. BLDG. RENOVATION			1986	10,307	258	40	258		6,961	10
11	LAND IMPROVEMENTS (CURBS, LIGHTS, ETC.)			1988	160,000		10			160,000	11
12	WATER CONDITIONER			1988	5,417		20	217	217	4,554	12
13	SIGN RENOVATION			1988	2,490		20	125	125	2,250	13
14	INSTALLATION OF VERTICAL BLINDS			1998	1,582		20	79	79	1,501	14
15	INSTALLATION OF TIME CLOCK			1988	8,273		20	414	414	7,451	15
16	LAND IMPROVEMENTS			1990	5,035		20	252	252	4,031	16
17	COOLED CONDENSERS AND COMPRESSORS			1990	3,782		20	189	189	2,741	17
18	ROOF REPAIRS			1990	15,370		10			15,370	18
19	(20) RADIATOR VALVES			1991	7,200		20	360	360	5,541	19
20	TOILET FRAMES AND OTHER EQUIP.			1991	2,114		20	106	106	1,632	20
21	RUBBER ROOF SYSTEM			1992	74,550		10			74,550	21
22	WALK AND PATIO CONSTRUCTION			1992	9,255		10			9,255	22
23	PATIO FENCE			1992	3,620		10			3,620	23
24	WIRE GLASS DOOR			1992	509		20	25	25	330	24
25	CUBICAL CURTINS AND TRACK			1992	5,762		20	288	288	3,801	25
26	(49) MIRRORS			1992	4,470		20	224	224	2,956	26
27	SMOKE DAMPERS, FIREWALL AND VENT. RENOV.			1993	1,174		20	59	59	663	27
28	DUMPSTER PAD			1993	2,450		20	122	122	1,371	28
29	WANDER SAF-T-LOCK ALARM SYSTEM			1993	16,030		20	802	802	9,010	29
30	SKILLED WING DINNING ROOM RENOVATION			1993	2,900		20	73	73	1,558	30
31	ISE GARBAGE DISPOSAL			1993	603		20	30	30	342	31
32	KITCHEN COUNTER AND FIRE DOOR			1994	1,945		10			1,945	32
33	DINNING ROOM CARPETING			1994	7,832		10			7,832	33
34	BOILER			1997	3,016	301	10	301		2,287	34
35	3" BACKFLOW PREVENTOR			1999	4,935	494	10	494		3,002	35
36	CARPETING			1999	20,943		10	2,094	2,094	13,264	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BOOSTER HEATER	1999	$ 977	$ 97	10	$ 97	$	$ 570	37
38	20" MARATON 1200 EXTRACTOR	2001	1,673	168	10	168		739	38
39	WATER SOFTNER	2001	5,700	570	10	570		2,423	39
40	ASPHAL REMOVAL AND REPLACEMENT	2001	22,094	2,208	10	2,208		8,653	40
41	REPAIR AND REPLACE DAMAGED SHOWER STALLS	2002	32,044	3,205	10	3,205		11,324	41
42	REPAIR AND REPLACE DAMAGED SHOWER STALLS	2002	6,400	640	10	640		1,707	42
43	REPAIR FLOOR IN DINING ROOM	2002	12,639	1,264	10	1,264		3,897	43
44	REPAIR AND REPLACE DAMAGED SHOWER STALLS	2003	6,400	640	10	640		1,600	44
45	REMODEL OXYGEN ROOM	2005	34,523	288	10	288		288	45
46	OTHER ASSETS & IMPAIRMENTS NOT ALLOWED			(30,738)			30,738		46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,093,780	$ 20,524		$ 80,336	$ 59,812	$ 1,475,752	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 46,060	$ 4,929	$ 4,929	$	5 TO 10	$ 31,305	71
72	Current Year Purchases	0				5 TO 10	0	72
73	Fully Depreciated Assets	406,920				5 TO 10	406,920	73
74								74
75	TOTALS	$ 452,980	$ 4,929	$ 4,929	$		$ 438,225	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT OUTINGS	1990 FORD CLUB WAGON	1999	$ 2,740	$ 419	$ 419	$	6	$ 2,740	76
77										77
78										78
79										79
80	TOTALS			$ 2,740	$ 419	$ 419	$		$ 2,740	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,795,500	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,872	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 85,684	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 59,812	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,916,717	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 13,407 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$		$ 93,652	$ 488		$ 94,140	1
2	Licensed Speech and Language Development Therapist	10a	hrs			34,892			34,892	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs			87,622	807		88,429	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 216,166	$ 1,295		$ 217,461	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 24,035	$ 114,182	1
2	Cash-Patient Deposits		185,996	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 92,355)	443,322	2,470,396	3
4	Supply Inventory (priced at Cost)	6,568	49,792	4
5	Short-Term Investments		117,892	5
6	Prepaid Insurance	25,748	192,006	6
7	Other Prepaid Expenses	16,813	60,347	7
8	Accounts Receivable (owners or related parties)		8,108,571	8
9	Other(specify): See Attached		970,276	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 516,486	$ 12,269,458	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		876,458	13
14	Buildings, at Historical Cost		21,948,912	14
15	Leasehold Improvements, at Historical Cost		696,172	15
16	Equipment, at Historical Cost		5,625,823	16
17	Accumulated Depreciation (book methods)		(22,213,455)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached		5,459,629	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 12,393,539	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 516,486	$ 24,662,997	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,946	$ 1,452,587	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,091	212,129	28
29	Short-Term Notes Payable	96,902	14,149,540	29
30	Accrued Salaries Payable	161,032	882,702	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,710	20,231	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		121,367	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Affiliates	2,782,588	24,653,282	36
37	Deferred Revdenue		233,216	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,143,269	$ 41,725,054	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	137,162	151,229	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Revdenue		116,279	43
44	Other		89,783	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 137,162	$ 357,291	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,280,431	$ 42,082,345	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,763,945)	$ (17,419,348)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 516,486	$ 24,662,997	48

*(See instructions.)

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,589,568)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,589,568)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(174,584)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Change in Restricted Donations**	207	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (174,377)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,763,945)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,149,533	1
2	Discounts and Allowances for all Levels	(2,225,808)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,923,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	967,337	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 967,337	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	5,894	12
13	Barber and Beauty Care	1,783	13
14	Non-Patient Meals	14,467	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	6,210	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 28,354	23
	D. Non-Operating Revenue		
24	Contributions	8,670	24
25	Interest and Other Investment Income***	640	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 9,310	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,928,726	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	793,035	31
32	Health Care	2,438,656	32
33	General Administration	1,589,543	33
	B. Capital Expense		
34	Ownership	215,087	34
	C. Ancillary Expense		
35	Special Cost Centers	14,429	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,103,310	40
41	**Income before Income Taxes (line 30 minus line 40)****	(174,584)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (174,584)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,041	2,105	$ 61,350	$ 29.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	23,224	25,103	593,458	23.64	3
4	Licensed Practical Nurses	13,233	14,496	321,246	22.16	4
5	CNAs & Orderlies	52,328	58,237	699,660	12.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,924	2,080	43,449	20.89	9
10	Activity Assistants	1,792	2,080	27,146	13.05	10
11	Social Service Workers	2,236	2,417	62,227	25.75	11
12	Dietician					12
13	Food Service Supervisor	1,912	2,080	43,394	20.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,822	18,380	151,988	8.27	15
16	Dishwashers					16
17	Maintenance Workers	3,314	3,636	68,970	18.97	17
18	Housekeepers	9,923	11,222	110,047	9.81	18
19	Laundry					19
20	Administrator	2,008	2,080	80,063	38.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,915	2,080	40,027	19.24	23
24	Clerical	5,413	5,962	68,236	11.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,958	2,182	31,610	14.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,043	154,140	$ 2,402,871 *	$ 15.59	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	156	$ 6,960	1-3	35
36	Medical Director		13,800	9-3	36
37	Medical Records Consultant	25	1,110	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,116	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	576	11-3	44
45	Social Service Consultant	12	700	12-3	45
46	Other(specify)				46
47	Dental Consultant		3,456	39-3	47
48					48
49	TOTAL (lines 35 - 48)	203	$ 27,718		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	372	$ 18,646	10-3	50
51	Licensed Practical Nurses	669	24,845	10-3	51
52	Certified Nurse Assistants/Aides	992	21,152	10-3	52
53	TOTAL (lines 50 - 52)	2,033	$ 64,643		53

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marsha Quale	Administrator		$ 80,063
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,063

B. Administrative - Other

Description	Amount
NONE	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Lifelink Corporation	Mgmt. Fee	$ 4,321
Lifelink Corporation	Data Processing	32,744
Lifelink Corp. & BHS Corp.	Allocated M & G	457,152
Reingruber & Company	Medicare Consultant	3,473
Rever Health Care	A/R Consultant	15,369
Amex	Billing Review	6,268
Cain Brothers	Appraisal	50,960
Interlinks	Sale Web Site	8,694
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 578,981

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,010
Unemployment Compensation Insurance	20,600
FICA Taxes	173,556
Employee Health Insurance	306,583
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance/Disability	11,418
Pension(TSA)	9,227
Employee Relations/Etc.	10,534
Staff Medical Exams	3,181
Prffessional Soc.	197
Allocation Schedule VIII - B	18,136
TOTAL (agree to Schedule V, line 22, col.8)	$ 624,442

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	99
Health Care Worker Background Check	487
(Indicate # of checks performed 69)	
Subscriptions/Reference Publications	6,827
Dues	(305)
Public Relations	4,779
	25
Allocation Schedule VIII - B	173
Allocation Schedule VII - B	
Less: Public Relations Expense	(4,779)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,306

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
AAHSA	1,502
In-State Travel	
Seminar Expense	2,678
Allocation Schedule VIII - B	411
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,591

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3	NONE												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Anchorage of Beecher # 0033803 Report Period Beginning: 07/01/04 Ending: 06/30/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **NO**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **29,979** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? **NO** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. $ **52,560**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **NO** Indicate the amount. $ **O**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **NO** If no, please explain. **AUDIT HAS NOT BEEN ISSUED**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

BENSENVILLE HOME SOCIETY

REPORTING PERIOD 07/01/04 - 06/30/05

IX INTEREST EXPENSE

FACILITY NUMBEINAME

0014258	ANCHORAGE OF BENSENVILLE
0033803	ANCHORAGE OF BEECHER
0039289	PINE ACRES CARE CENTER

THE BENSENVILLE HOME SOCIETY (BHS) IN CONJUNCTION WITH ITS AFFILIATED CORPORATIONS, LIFELINK AND BRIDGEWAY OF BENSENVILLE, HAVE ISSUED 1989A, 1995A, AND 1998 BONDS THRU THE ILLINOIS HEALTH FACILITY AUTHORITY ON VARIOUS DATES. SEE COPY OF OFFICIAL STATEMENTS ATTACHED. THE 1989B AND 1995B BONDS WERE RETIRED WITH THE ISSUANCE OF THE 1998 BONDS.

INTEREST PAID AND ACCRUED

1989A SERIES	62,721
1995A SERIES	195,179
1998 SERIES	970,017

LETTER OF CREDIT AND OTHER FEES

1989A SERIES	57,430
1995A SERIES	144,776
1998 SERIES	4,000
TOTAL	1,434,123

INTEREST HAS BEEN ALLOCATED BASED ON THE USE OF THE BOND PROCEEDS.

ANCHORAGE OF BENSENVILLE	34.2% OF 1989 BONDS	41,092
	13.2% OF 1995 BONDS	43,924
	8.8% OF 1998 BONDS	85,817
	TOTAL	170,833
ANCHORAGE OF BEECHER	44.5% OF 1989 BONDS	53,477
	11.5% OF 1998 BONDS	111,659
	TOTAL	165,136
PINE ACRES CARE CENTER	30.3% OF 1995 BONDS	100,846
OTHER*		997,308
	TOTAL	1,434,123

* CORPORATE AND PARENT CORPORATE OFFICES AND NON-CARE RELATED.

LIFELINK CORPORATION

BENSENVILLE HOME SOCIETY

ANCHORAGE OF BENSENVILLE	#	0014258
ANCHORAGE OF BEECHER	#	0033803
PINE ACRES CARE CENTER	#	0039289

SCHEDULE VII-A

ATTACHED ARE LISTS OF THE BOARD OF DIRECTORS FOR LIFELINK CORPORATION AND BENSENVILLE HOME SOCIETY.

NONE OF THESE DIRECTORS PROVIDE ANY SERVICES TO EITHER CORPORATION NOR DO THEY HAVE ANY OWNERSHIP IN ANY ENTITY THAT DOES BUSINESS WITH EITHER CORPORATION.

SCHEDULE VII-A3

NAME	CITY	TYPE OF BUSINESS
Hoyleton Youth and Family Services	Hoyleton	Social Services
Hoyleton Children's Home Foundation	Hoyleton	Fund Raising

BENSENVILLE HOME SOCIETY
SCHEDUAL VII-B
6/30/2005

RECAP

VICE PRESIDENT OF HEALTH CARE (020-050)

LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	ANCHORAGE OF BENSENVILLE	ANCHORAGE OF BEECHER	PINE ACRES CARE CENTER
2	FOOD PURCHASES		-	-	-	-	-
11	ACTIVITIES	-	-	-	-	-	-
17	ADMINISTRATIVE		-	-	-	-	-
19	PROFESSIONAL SERVICES	3,050		3,050	1,220	915	915
20	FEES, SUBSCRIPTIONS, PROM.	10,084	10,000	84	34	25	25
21	GENERAL OFFICE EXPENSE	1,268	-	1,268	507	380	380
22	EMPLOYMENT BENEFITS & TX.			-	-	-	-
24	TRAVEL AND SEMINARS		-	-	-	-	-
25	OTHER STAFF TRANSPORT.		-	-	-	-	-
34	RENT-FACILITIES & GROUND			-	-	-	-
35	RENTAL EQUIPMENT	-	-	-	-	-	-
	TOTAL	14,402	10,000	4,402	1,761	1,321	1,321
	ALLOCATION %				40.0%	30.0%	30.0%

XII B. # 16 EQUIPMENT RENTAL (PAGE14)

07/01/04 - 06/30/05

1. ADVACARE		
	VARIOUS MEDICAL EQUIPMENT	7,701.50
2. AMERICAN MEDICAL OXYGEN SALES		
	PORTABLE LIQUID QXYGEN	789.00
3. KCI THERAPUETICS		
	VARIOUS MEDICAL EQUIPMENT	3,315.00
4. GENESIS MEDICAL		
	BLUE SKY VERSATILE	1,125.00
5 PBCC		
	MAIL MACHINE	470.74
6. ARCH WIRELESS		5.25
		13,406.49

BENSENVILLE HOME SOCIETY

REPORTING PERIOD 07/01/04 - 06/30/05

FACILITY NUMBER	NAME
0014258	ANCHORAGE OF BENSENVILLE
0033803	ANCHORAGE OF BEECHER
0039289	PINE ACRES CARE CENTER

SCHEDULE XV BALANCE SHEET (AFTER CONSOLIDATION)

LINE 9 - OTHER

GRANTS RECEIVABLE	63,777
CONTRIBUTIONS RECEIVABLE	333,922
ASSETS HELD BY TRUSTEE	572,577
	970,276

LINE 23 - OTHER

BENEFICIAL INTEREST IN PERPETUAL TRUST	4,498,250
STUDENT LOANS RECEIVABLE	43,689
CASH RESTRICTED FOR STUDENT LOANS	29,789
DEFERRED COSTS AND OTHER INTANGIBLES, NET	658,203
OTHER ASSETS, NET	227,514
DUE FROM AFFILIATED CORPORATIONS	2,184
	5,459,629

BENSENVILLE HOME SOCIETY

REPORTING PERIOD 07/01/04 - 06/30/05

FACILITY NUMBER NAME

0033803 ANCHORAGE OF BEECHER

SCHEDULE XVII - LINE 41

	(1) BENSENVILLE HOME SOCIETY	(2) FACILITY	BHS RELATED (1) - (2)
ANCHORAGE OF BEECHER			
REVENUES	34,618,346	4,928,726	29,689,620
EXPENSES	35,587,146	5,103,310	30,483,836
NET INCOME (LOSS) FROM OPERATIONS	(968,800)	(174,584)	(794,216)

DESCRIPTION OF LINE 24, SCHEDULE V:

NAME	JOB TITLE	DATE	LOCATION	SEM. TITLE	SPONSOR	COST
PAT BAILEY	ACTIVITIES DIR.	10/20-10/22/05	DECATUR	I.A.P.A. CONVENTION	I.A.P.A.	$ 622.15
MARSHA QUALE	ADMINISTRATOR	4/20-4/22/05	CHICAGO	LSN CONFERENCE	LSN	$ 1,300.00
PAT RENZETTI	SOC. SERV. DIR.					
PAT BAILEY	ACTIVITIES DIR.					
JANICE BRAUN	FOOD SER. DIR.					
FRANCES GRAY	NURSING SUPERV.					
DONNA FOX	D.O.N.					
JENNIFER MAGRUDER	MDS/CP COOR.					
ROCHELLE PERNICK	BILLING SUP.					
MARY ELLEN KOSKY	ASSIST. ACT. DIR.					
ALL OTHER SEMINARS LESS THAN $250.00:						$ 756.00
ALLOCATED COSTS - SCHEDULE VII B:						$ -
ALLOCATED COSTS - SCHEDULE VIII B:						$ 411.00
SUB-TOTAL						$ 3,089.15
OUT OF STATE SEMINARS/CONFERENCES						$ 1,502.00
TOTAL						$ 4,591.15

DESCRIPTION OF LINE 25, SCHEDULE V:

NAME	JOB TITLE	DATE	REASON FOR TRAVEL	COST
REV. MICHAEL KIRCHOFF	CHAPLIN	7/1/04-6/30/05	TRAVEL FROM ANCHORAGE OF BENSENVILL TO ANCHORAGE OF BECHER TO PERFORM DUTIES	$ 2,784.73

ALL OTHER SEMINARS LESS THAN $250.00:	$	209.00
ALLOCATED COSTS - SCHEDULE VII B:	$	-
ALLOCATED COSTS - SCHEDULE VIII B:	$	103.00
TOTAL	$	3,096.73

BENSENVILLE HOME SOCIETY

SCHEDUAL XI - LINES 9 & 10

1985 / 1986 ALLOCATION OF RENOVATION COSTS FOR THE CFS BUILDING

	1985	1986
CONSTRUCTION COSTS:	1,735,410	133,721
CURRENT DEPRECIATION:	43,385	3,343

FACILITY FY 2002:	BENSENVILLE	BEECHER	PINE ACRES
FACILITY OPERATING EXP. (A)	10,627,094	5,103,310	4,980,900
TOTAL OPERATING EXP. (B)	66,207,782	66,207,782	66,207,782
(A) / (B)	16.05%	7.71%	7.52%

1985 COST PERCENTAGE	278,553	133,766	130,557
1985 DEPRECIATION PERCENT.	6,964	3,344	3,264
1986 COST PERCENTAGE	21,464	10,307	10,060
1986 DEPRECIATION PERCENT.	537	258	252

BENSENVILLE HOME SOCIETY
INDIRECT COSTS
SCHEDULE VIII-B
6/30/2005

RECAP

LINE #	DESCRIPTION	0014258 ANCHORAGE OF BENSENVILLE	0033803 ANCHORAGE BEECHER	0039289 PINE ACRES CARE CENTER
2	FOOD PURCHASES	-	-	-
17	ADMINISTRATIVE	189,769	91,160	88,914
19	PROFESSIONAL SERVICES	39,152	18,807	18,344
20	FEES, SUBSCRIPTIONS, PROM.	360	173	169
21	GENERAL OFFICE EXPENSE	9,950	4,780	4,662
22	EMPLOYMENT BENEFITS & TX.	37,764	18,141	17,694
24	TRAVEL AND SEMINARS	855	411	401
25	OTHER STAFF TRANSPORT.	214	103	100
26	INSURANCE	-	-	-
34	RENT-FACILITIES & GROUND	-	-	-
35	RENTAL EQUIPMENT	243	117	114
	TOTAL	278,306	133,691	130,396
	ALLOCATION	16.05%	7.71%	7.52%

		LIFELINK ADMINISTRATION (010)			LIFELINK BOARD & CORPORATE (020)		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	2,251	2,251	-	-	-	-
17	ADMINISTRATIVE	613,160	291,000	322,160	-	-	-
19	PROFESSIONAL SERVICES	3,570	3,525	45	4,700	-	4,700
20	FEES, SUBSCRIPTIONS, PROM.	621	230	391	-	-	-
21	GENERAL OFFICE EXPENSE	17,709	-	17,709	47	-	47
22	EMPLOYMENT BENEFITS & TX.	89,495	42,473	47,022	-	-	-
24	TRAVEL AND SEMINARS	12,739	7,413	5,326	-	-	-
25	OTHER STAFF TRANSPORT.	1,009	-	1,009	-	-	-
26	INSURANCE	-	-	-	4,092	4,092	-
34	RENT-FACILITIES & GROUND	36,053	36,053	-	-	-	-
35	RENTAL EQUIPMENT	1,043	-	1,043	-	-	-
	TOTAL	777,650	382,945	394,705	8,839	4,092	4,747

		LIFELINK BUSINESS OFFICE (030)			LIFELINK SUPPORT SERVICES (080)		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	128	128	-	-	-	-
17	ADMINISTRATIVE	598,987	48,138	550,849	159,820	32,503	127,317
19	PROFESSIONAL SERVICES	1,525,868	1,388,144	137,724	229	229	-
20	FEES, SUBSCRIPTIONS, PROM.	1,587	550	1,037	84	-	84
21	GENERAL OFFICE EXPENSE	22,595	-	22,595	918	-	918
22	EMPLOYMENT BENEFITS & TX.	127,118	10,216	116,902	27,857	5,665	22,192
24	TRAVEL AND SEMINARS	1,674	1,674	-	-	-	-
25	OTHER STAFF TRANSPORT.	323	-	323	-	-	-
26	INSURANCE	-	-	-	-	-	-
34	RENT-FACILITIES & GROUND	54,672	54,672	-	4,416	4,416	-
35	RENTAL EQUIPMENT	402	-	402	-	-	-
	TOTAL	2,333,354	1,503,522	829,832	193,324	42,813	150,511

		LIFELINK MATERIALS HANDLING (110)			LIFELINK HUMAN RESOURCES (120)		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	-	-	-	17	17	-
17	ADMINISTRATIVE	66,183	-	66,183	115,853		115,853
19	PROFESSIONAL SERVICES	5,736	-	5,736	21,150		21,150
20	FEES, SUBSCRIPTIONS, PROM.	152	68	84	646		646
21	GENERAL OFFICE EXPENSE	1,327	-	1,327	8,327		8,327
22	EMPLOYMENT BENEFITS & TX.	23,983	-	23,983	25,190		25,190
24	TRAVEL AND SEMINARS	-	-	-			-
25	OTHER STAFF TRANSPORT.	-	-	-			-
26	INSURANCE	-	-	-			-
34	RENT-FACILITIES & GROUND	804	804	-	22,176	22,176	-
35	RENTAL EQUIPMENT	69	-	69			-
	TOTAL	98,254	872	97,382	193,359	22,193	171,166

		BHS G&A BOARD & CORPORATE (010-020)			GRAND TOTAL		
LINE #	DESCRIPTION	TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	-	-	-	2,396	2,396	-
17	ADMINISTRATIVE	-	-	-	1,554,003	371,641	1,182,362
19	PROFESSIONAL SERVICES	74,580	-	74,580	1,635,833	1,391,898	243,935
20	FEES, SUBSCRIPTIONS, PROM.	-	-	-	3,090	848	2,242
21	GENERAL OFFICE EXPENSE	11,070	-	11,070	61,993	-	61,993
22	EMPLOYMENT BENEFITS & TX.	-	-	-	293,643	58,354	235,289
24	TRAVEL AND SEMINARS	-	-	-	14,413	9,087	5,326
25	OTHER STAFF TRANSPORT.	-	-	-	1,332	-	1,332
26	INSURANCE	1,828	1,828	-	5,920	5,920	-
34	RENT-FACILITIES & GROUND	-	-	-	118,121	118,121	-
35	RENTAL EQUIPMENT	-	-	-	1,514	-	1,514
	TOTAL	87,478	1,828	85,650	3,692,258	1,958,265	1,733,993

FACILITY ID#: 0033803

FACILITY NAME: ANCHORAGE OF BEECHER
A FACILITY OF THE BENSENVILLE HOME SOCIETY

REPORT PERIOD: 07/01/04 - 06/30/05

SCHEDULE V

RECLASSIFICATIONS AND ADJUSTMENTS:

1.	LINE 21 CLERICAL & GENERAL	594	
	LINE 10 NURSING & RECORD KEEPING	12,930	
	LINE 35 RENT - EQUIPMENT		13,524
	TO RECLASSIFY RENTAL EQUIPMENT TO PROPER ACCOUNTS PER SCHEDULE XII B #16.		
2	LINE 20 FEES, SUBSCRIPTIONS, PROM.	25	
	LINE 21 CLERICAL & GENERAL OFFICE	380	
	LINE 19 PROFESSIONAL SERVICES		405
	TO RECLASSIFY MANAGEMENT FEES FROM PROFESSIONAL SERVICES TO PROPER ACCOUNTS.		
3	LINE 41 GIFT & COFFEE SHOP	5,894	
	LINE 2 FOOD PURCHASES		5,894
	TO RECLASSIFY COFFEE SHOP EXPENSES		
4	LINE 39 ANCILLARY SERVICE CENTER	74,450	
	LINE 10 NURSING & RECORD KEEPING		74,450
	TO RECLASSIFY PRIVATE PAY DRUGS TO SECTION D		
5.	LINE 17 ADMINISTRATIVE	91,137	
	LINE 20 FEES, SUBSCRIPTIONS, PROM.	173	
	LINE 21 CLERICAL & GENERAL OFFICE	4,778	
	LINE 22 EMPLOYMENT BENEFITS & TAXES	18,136	
	LINE 24 TRAVEL & SEMINARS	411	
	LINE 25 OTHER STAFF TRANSPORTATION	103	
	LINE 35 RENTAL EQUIPMENT	117	
	LINE 19 PROFESSIONAL SERVICES		114,855
	TO RECLASSIFY ALLOCATED MANAGEMENT AND GENERAL COSTS FROM PROFESSIONAL SERVICES TO PROPER ACCOUNTS.		

RECAP ABOVE ENTRIES

LINE 2 FOOD PURCHASES		5,894
LINE 10 NURSING & RECORD KEEPING		61,520
LINE 11 ACTIVITIES		
LINE 17 ADMINISTRATIVE	91,137	
LINE 19 PROFESSIONAL SERVICES		115,260
LINE 20 FEES, SUBSCRIPTIONS, PROM.	198	
LINE 21 CLERICAL & GENERAL OFFICE	5,752	
LINE 22 EMPLOYMENT BENEFITS & TAXES	18,136	
LINE 24 TRAVEL & SEMINARS	411	
LINE 25 OTHER STAFF TRANSPORTATION	103	
LINE 35 RENT - EQUIPMENT		13,407
LINE 39 ANCILLARY SERVICE CENTER	74,450	
LINE 41 GIFT & COFFEE SHOP	5,894	